CONFIDENTIAL

REASONABLE ACCOMMODATION REQUEST FORM

To be completed by employee or job applicant requesting accommodation. Send to: (mail) Human Resources, 83 Windham Street, Gelsi-Young Room 331, Willimantic, CT 06226; (scan) humanresources@easternct.edu: (fax) 860-465-4652.

This form will be used by Eastern Connecticut State University (Eastern) employees and/or applicants for employment who believe they have a disability and wish to request a reasonable accommodation under the Americans with Disabilities Act (ADA) or other applicable State and Federal civil rights laws. By considering this request, Eastern does not consider or regard the person making the request as having a disability as defined by the ADA, the Connecticut Fair Employment Practices Act, or any other applicable law.

The purpose of this form is to assist Eastern in determining whether, or to what extent, a reasonable accommodation is appropriate for an employee or applicant for employment. This form must be maintained separately from the employee's personnel file and is a confidential document.

Fill out all sections that apply to you

Name: _____ Phone #: _____

Date of Request: _____

Job Title/Classification: _____

Supervisor's Name: _____ Phone #: _____

Department/Unit: _____

If job applicant, for what position are you applying?

_____

1. Identify the physical and/or mental impairment(s) for which you are requesting an accommodation and expected prognosis/duration of the impairment(s).

2. Explain how the impairment(s) listed in #1 affects your ability to perform the essential function(s) of the job/job applying for.

3. List the accommodation(s) you are requesting.

4. Medical verification of impairment from my physician or health care provider (check the appropriate box):

   ☐ I have enclosed the documentation for this request.

   ☐ The disability and the need for reasonable accommodation is obvious and no medical documentation is needed.

I, _____, give Eastern permission to explore coverage and reasonable accommodations under the Americans with Disabilities Act of 1990, and all applicable State and Federal laws. I understand that all information obtained during this process will be maintained and used in accordance with the ADA, including its confidentiality requirements.

Signature of Employee: _____

Date: _____

To Be Completed by the Employer

ADA Coordinator Accommodation Request is: Approved _____ Denied _____

Modified (Explain below):

Signature of Human Resources: _____

HEALTH CARE PROVIDER RELEASE FORM

I, _____ (employee/applicant), give Eastern Connecticut State University permission to contact _____ (health care provider) if necessary.

I understand the reason for this contact is to advise Eastern about my functional abilities and limitations in relation to my job functions. I understand that Eastern will supply my health care provider with specific information about the position, including the essential functions and specific requirements.

All information obtained from employee medical examinations and inquiries will be job-related and consistent with business necessity. All information obtained will be maintained and used in accordance with the Americans with Disabilities Act of 1990 confidentiality requirements, and all other applicable State and Federal laws.

Employee Signature: _____

Date: _____